AIA Bhd. (790895-D)
Corporate Solutions Division
Menara AIA, 99 Jalan Ampang, 50450 Kuala Lumpur
P. O. Box 10140, 50704 Kuala Lumpur
T : 03-2056 1111

CLAIM NO. For Office Use Only

Corporate Solutions - Hospital & Surgical Claim
July 2018

IMPORTANT NOTE

1. One form for **ONE** admission and related to Pre & Post visit.
2. Claim for hospitalisation & surgical expenses must be submitted within 90 days from the date of discharge or consultation.
3. For Overseas Treatment, the original Detailed Admission Bill showing details of each charges must be provided. English translation must be provided if the bill is in foreign language.
4. AIA Bhd. will keep the claim documents unless you requested for the documents to be returned to you within 60 days from the decision of the claim.
5. A copy of Identity Card (NRIC) or Passport must be provided.
6. Field marked with (*) is compulsory.

CHECKLIST ON SUBMISSION OF CLAIM DOCUMENTS

TYPE OF CLAIM

☐ Hospitalisation / Daycare Treatment

- *1. Copy of Identity Card (NRIC) or Passport
- *2. Original Official Receipt (Deposit & Final Payment)
- 3. Detailed Itemised Bill
- 4. Medical Report / Section II of this form
  - For Government Hospital bill above RM1,000.
  - For Private Hospital bill above RM500.
- 5. Copy of Investigation Report [Lab / Imaging / Procedure Performed (if any)]
- 6. Physiotherapy Details - visit date & amount for each treatment session done (Advance payment NOT accepted)

GHS1

☐ Pre & Post Hospitalisation

- *1. Copy of Identity Card (NRIC) or Passport
- *2. Original Official Receipt (Deposit & Final Payment)
- 3. Detailed Itemised Bill
- 4. Copy of Investigation Report [Lab / Imaging / Procedure Performed (if any)]
- 5. Physiotherapy Details - visit date & amount for each treatment session done (Advance payment NOT accepted)

POST

☐ Accidental Claim

- *1. Copy of Identity Card (NRIC) or Passport
- *2. Original Official Receipt (Deposit & Final Payment)
- 3. Detailed Itemised Bill
- 4. Medical Report / Section II of this form
  - For Government Hospital bill above RM1,000.
  - For Private Hospital bill above RM500.
- 5. Copy of Investigation Report [Lab / Imaging / Procedure Performed (if any)]
- 6. Copy of Police Report (if any)

GHS1

Assessment of the claim may be delayed if documents are incomplete.

SECTION I - To be completed by the Employee / Patient (IN BLOCK LETTERS)

A. EMPLOYEE INFORMATION

*Name of Employee (as in NRIC)

*Employee NRIC No. / Passport No.

Policy No.

Plan

*Mobile No. -

This number will be used for your claim status notification.

Occupation

Date of Employment d d - m m - y y y y

Date of Group Insurance Participation d d - m m - y y y y

Gender ☐ Male ☐ Female

*Email Address

*Name of Company / Employer

B. PATIENT INFORMATION

*Name of Patient ☐ Same as above

*Membership No. (as in Member ID Card)

Gender ☐ Male ☐ Female

Relationship to Employee ☐ Spouse ☐ Child

C. FOR ACCIDENTAL CAUSE ONLY

*Date of Accident d d - m m - y y y y

*Time : ☐am ☐pm

*Details of Accident (brief explanation of the cause):

D. DETAILS OF OTHER INSURANCE POLICIES, SOCSO, WORKMEN'S COMPENSATION AND OTHERS

Policy Type ☐ Hospital & Surgical ☐ Other(s) ____________________ (e.g. SOCSO)

Policy No.

Insurance Company

☐ Not insured under any program, benefits, schemes or insurance.

E. CLAIM AMOUNT

*RM .

F. *E-PAYMENT REGISTRATION (MANDATORY REQUIREMENT)

☐ Change of account number for this claim and future transactions.

☐ Use the existing payment details in AIA Bhd. record.

Notes:
(a) AIA shall not be responsible for losses as a result of inaccurate account details provided.
(b) Only employee bank account details allowed.

Bank Name

Bank Account Holder Name

Bank Account No.

IP_06/2018/Ver2

G. DECLARATION AND AUTHORISATION

1. I/We confirm that the information given are true and accurate.
2. I/We understand that for Overseas Treatment, I/we must include Original Detailed Admission Bill showing details of each charges. The bill must have an English translation if it is in a foreign language.
3. I/We understand AIA Bhd. will keep my/our claim documents unless if I/we request for the documents to be returned to me within 60 days from the decision of claim.
4. I/We understand that AIA Bhd.'s acceptance of this Hospital & Surgical Claim Form is not an admission of AIA Bhd.'s liability of my/our claim.
5. I/We authorise any institution or individual that has any records or knowledge of my/our health and medical history to disclose such information to AIA Bhd. or its representative.
6. I/We understand and agree that any personal information collected or held by AIA Bhd. (whether through this Hospital & Surgical Claim form or otherwise obtained) may be used and disclosed by AIA Bhd. to individuals/institutions related to and associated with AIA Bhd. or any selected third party within or outside Malaysia such as reinsurers, claims investigation companies and industry associations to process this Hospital & Surgical Claim form. The information may also be used to provide service for this and other financial products and to communicate with me/us. I/We understand that I/we have a right to get access to and request for correction of any personal information held by AIA Bhd. Such requests can be made at any AIA Bhd. Customer Centres.

Employer's Signature, Stamp & Address

______________________ Signature of Employee

______________________ Date

SECTION II - To be completed by the Attending Doctor (IN BLOCK LETTERS) - Please answer all questions

MRN No.:

1. a) Patient Name
   b) NRIC
   c) Age
   d) Gender ☐ Male ☐ Female

2. Admission Date and Time
   d d - m m - y y y y __ : __ (hrs)

3. Discharge Date
   d d - m m - y y y y

4. Date of MC
   d d - m m - y y y y to d d - m m - y y y y

   No. of MC days

5. a) Symptoms / Conditions requiring admission:
   b) How long is patient aware of the condition:
   c) Patient's BP / Temp / Pulse:
   d) Date symptoms first appeared: d d - m m - y y y y
   e) Date first consulted: d d - m m - y y y y

6. a) Any previous consultation / treatment / hospitalisation for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities?
   ☐ Yes ☐ No
   b) Was this patient referred? If Yes, please provide details:
   c) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:

Date	Disease / Disorder	Details of Treatment / Hospitalisation	Doctor / Hospital / Clinic

   d) Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No

   If No, please provide reasons of admission: ______________________

7. Any other medical / surgical conditions present? ☐ No ☐ Yes, details below:
   a) ______________________ since d d - m m - y y y y
   b) ______________________ since d d - m m - y y y y

8. a) Final Diagnosis / ICD Coding
   i)
   ii)
   iii)

   b) Cause and pathology of the diagnosis:

9. Treatment given / Investigation done (Please supply copy of all investigation results):

10. a) Surgical procedures performed:

    MMA code / PHFSR code:

    b) Date of surgery / procedure: d d - m m - y y y y

11. Is the illness / condition related to: (please tick ✓ if YES)
    a) ☐ Childbirth / Infertility / Caesarean Section / Miscarriage or Any Complications Arising Therefrom
    b) ☐ Congenital / Hereditary Disease
    c) ☐ Influence of Drugs / Alcohol
    d) ☐ Nervous / Mental / Emotional / Sleeping Disorder
    e) ☐ Cosmetic Reason / Dental Care / Refractive Errors Correction
    f) ☐ AIDS / STD / VD / HIV
    g) ☐ Self-inflicted Injuries / Violation of Laws / Strike / Riots
    h) ☐ None of the above

12. Was the patient pregnant at the time of hospitalisation? (For Females Only) ☐ No ☐ Yes, __________ months

13. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated above represent my medical opinion of his / her condition.

______________________ Name & Signature of Attending Doctor

______________________ Doctor / Hospital Stamp

______________________ Date

IP_06/2018/Ver2

AIA Bhd. (790895-D)
Corporate Solutions Division
Menara AIA, 99 Jalan Ampang, 50450 Kuala Lumpur
P. O. Box 10140, 50704 Kuala Lumpur
T : 03-2056 1111

NO. TUNTUTAN Untuk Kegunaan Pejabat Sahaja

Corporate Solutions - Tuntutan Hospital & Pembedahan
July 2018

NOTA PENTING

1. Setiap borang tuntutan adalah untuk **SATU** kemasukan ke hospital & lawatan sebelum & selepas yang berkaitan dengannya.
2. Tuntutan hospitalisasi & perbelanjaan pembedahan mesti dihantar dalam masa 90 hari daripada tarikh keluar hospital atau tarikh rundingan.
3. Untuk Rawatan Di Luar Negara, Butiran Bil Asal yang terperinci menyenaraikan butir-butir setiap caj perlu disertakan. Terjemahan Bahasa Inggeris perlu disertakan jika bil dalam bahasa asing.
4. AIA Bhd. akan menyimpan dokumen tuntutan melainkan anda memohon dokumen tersebut dikembalikan kepada anda dalam masa 60 hari dari tarikh keputusan tuntutan.
5. Salinan Kad Pengenalan (KP) atau Pasport perlu disertakan.
6. Ruangan bertanda (*) wajib diisi.

SENARAI SEMAK BAGI PENYERAHAN DOKUMEN-DOKUMEN TUNTUTAN

JENIS TUNTUTAN

☐ Kemasukan ke Hospital / Jagaan Harian

*1. Salinan Kad Pengenalan (KP) atau Pasport
*2. Resit Rasmi Asal (Deposit & Bayaran Akhir)
3. Butiran Bil Terperinci
4. Laporan Perubatan / Section II di dalam borang ini
   - Sekiranya bil melebihi RM1,000 untuk Hospital Kerajaan.
   - Sekiranya bil melebihi RM500 untuk Hospital Swasta.
5. Salinan Laporan Penyiasatan [Makmal / Pengimejan / Prosedur Dilakukan (jika ada)]
6. Maklumat Fisioterapi - tarikh rawatan dan jumlah bagi setiap sesi rawatan (Resit bayaran pendahuluan TIDAK akan diterima)

GHS1

☐ Pra & Selepas Rawatan Hospital

*1. Salinan Kad Pengenalan (KP) atau Pasport
*2. Resit Rasmi Asal (Deposit & Bayaran Akhir)
3. Butiran Bil Terperinci
4. Salinan Laporan Penyiasatan [Makmal / Pengimejan / Prosedur Dilakukan (jika ada)]
5. Maklumat Fisioterapi - tarikh rawatan dan jumlah bagi setiap sesi rawatan (Resit bayaran pendahuluan TIDAK akan diterima)

POST

☐ Tuntutan Kemalangan

*1. Salinan Kad Pengenalan (KP) atau Pasport
*2. Resit Rasmi Asal (Deposit & Bayaran Akhir)
3. Butiran Bil Terperinci
4. Laporan Perubatan / Section II di dalam borang ini
   - Sekiranya bil melebihi RM1,000 untuk Hospital Kerajaan.
   - Sekiranya bil melebihi RM500 untuk Hospital Swasta.
5. Salinan Laporan Penyiasatan [Makmal / Pengimejan / Prosedur Dilakukan (jika ada)]
6. Salinan Laporan Polis (jika ada)

GHS1

Penilaian ke atas tuntutan ini mungkin akan mengalami kelewatan jika dokumen tidak lengkap.

SEKSYEN I - Untuk diisi oleh Pekerja / Pesakit (DALAM HURUF BESAR)

A. MAKLUMAT PEKERJA

*Nama Pekerja (seperti di dalam KP)

*No. KP Pekerja / No. Pasport | No. Polisi | Pelan

*No. Tel. Bimbit ___ - ___ Nombor telefon ini akan digunakan untuk makluman tuntutan anda. | Pekerjaan

Tarikh Mula Bekerja h h - b b - t t t t | Tarikh menyertai Skim Insurans Berkumpulan h h - b b - t t t t | Jantina ☐ Lelaki ☐ Perempuan

*Alamat Emel

*Nama Syarikat / Majikan

B. MAKLUMAT PESAKIT

*Nama Pesakit ☐ Sama seperti di atas

*No. Keahlian (seperti di dalam Kad Keahlian) | Jantina ☐ Lelaki ☐ Perempuan | Hubungan dengan Pekerja ☐ Suami / Isteri ☐ Anak

C. UNTUK KES KEMALANGAN SAHAJA

*Tarikh Kemalangan h h - b b - t t t t | *Masa ___ : ___ ☐am ☐pm | *Butiran Kemalangan (penjelasan ringkas mengenai punca kemalangan):

D. BUTIR-BUTIR INSURANS LAIN, PERKESO, INSURANS PAMPASAN PEKERJA DAN LAIN-LAIN

Jenis Polisi ☐ Hospital & Pembedahan ☐ Lain-lain ____________________ (e.g. SOCSO) | No. Polisi

Syarikat Insurans ☐ Tidak dilindungi oleh mana-mana program, faedah ataupun skim insurans lain.

E. AMAUN YANG DITUNTUT

*RM ______ . ___

F. *PENDAFTARAN E-PEMBAYARAN (MANDATORI UNTUK DIISI)

☐ Perubahan nombor akaun bagi transaksi pembayaran masa hadapan.

☐ Gunakan butiran pembayaran sedia ada dalam rekod AIA Bhd.

Nama Bank

Nama Pemegang Akaun Bank

No. Akaun Bank

Nota:
(a) AIA tidak akan bertanggungjawab terhadap sebarang kerugian sekiranya maklumat akaun yang diberikan tidak tepat.
(b) Hanya maklumat akaun bank pekerja diterima.

IP_06/2018/Ver2

G. PENGAKUAN DAN PEMBERIAN KUASA

1. Saya/Kami mengesahkan bahawa maklumat yang diberikan adalah benar dan tepat.
2. Saya/Kami memahami bahawa untuk Rawatan Di Luar Negara, saya/kami perlu menyertakan Butiran Bil Asal yang terperinci menyenaraikan buti-butir setiap caj bil tersebut dan bil perlu diterjemahkan ke Bahasa Inggeris jika ianya dalam bahasa asing.
3. Saya/Kami memahami bahawa AIA Bhd. akan menyimpan dokumen tuntutan saya/kami melainkan jika saya/kami memohon untuk dokumen tersebut dikembalikan kepada saya/kami dalam masa 60 hari dari tarikh keputusan tuntutan.
4. Saya/Kami memahami bahawa penerimaan Borang Tuntutan Hospital & Pembedahan oleh AIA Bhd. tidak boleh dianggap sebagai penerimaan liabiliti ke atas tuntutan yang dibuat.
5. Saya/Kami memberi kuasa kepada mana-mana institusi atau individu yang mempunyai rekod atau maklumat tentang kesihatan dan sejarah perubatan saya/kami untuk mendedahkannya kepada AIA Bhd atau wakil AIA Bhd.
6. Saya/Kami memahami dan bersetuju bahawa maklumat peribadi yang dikumpul atau dipegang oleh AIA Bhd. (sama ada melalui Borang Tuntutan Hospital & Pembedahan ini ataupun cara lain) boleh digunakan dan didedahkan kepada individu atau institusi yang berkaitan dengan AIA Bhd. atau mana-mana pihak ketiga di dalam atau di luar Malaysia seperti penanggung insurans semula (reinsurer), syarikat penyiasatan tuntutan dan persatuan industri bagi memproses Borang Tuntutan Hospital & Pembedahan ini. Maklumat tersebut juga boleh digunakan untuk memberikan perkhidmatan ke atas permohonan ini dan juga produk kewangan lain. Saya/Kami memahami bahawa saya/kami mempunyai hak untuk mendapatkan dan memohon pembetulan dibuat ke atas mana-mana maklumat persendirian yang disimpan oleh AIA Bhd. Permohonan tersebut boleh dibuat di mana-mana cawangan Pusat Khidmat Pelanggan AIA Bhd.

		Tandatangan, Cop Rasmi & Alamat Majikan
______________________ Tandatangan Pekerja	______________________ Tarikh	

SECTION II - To be completed by the Attending Doctor (IN BLOCK LETTERS) - Please answer all questions **MRN No.:**

1. a) Patient Name b) NRIC c) Age d) Gender ☐ Male ☐ Female

2. Admission Date and Time
d d - m m - y y y y __ __ : __ __ (hrs)

3. Discharge Date
d d - m m - y y y y

4. Date of MC
d d - m m - y y y y to d d - m m - y y y y
No. of MC days

5. a) Symptoms / Conditions requiring admission:
b) How long is patient aware of the condition:
c) Patient's BP / Temp / Pulse:
d) Date symptoms first appeared: d d - m m - y y y y
e) Date first consulted: d d - m m - y y y y

6. a) Any previous consultation / treatment / hospitalisation for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities?
☐ Yes ☐ No
b) Was this patient referred? If Yes, please provide details:
c) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:

Date	Disease / Disorder	Details of Treatment / Hospitalisation	Doctor / Hospital / Clinic

d) Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No
If No, please provide reasons of admission: ____________________

7. Any other medical / surgical conditions present? ☐ No ☐ Yes, details below:
a) ____________________ since d d - m m - y y y y
b) ____________________ since d d - m m - y y y y

8. a) Final Diagnosis / ICD Coding
i)
ii)
iii)
b) Cause and pathology of the diagnosis:

9. Treatment given / Investigation done (Please supply copy of all investigation results):

10. a) Surgical procedures performed:
MMA code / PHFSR code:
b) Date of surgery / procedure: d d - m m - y y y y

11. Is the illness / condition related to: (please tick ✓ if YES)
a) ☐ Childbirth / Infertility / Caesarean Section / Miscarriage or Any Complications Arising Therefrom
b) ☐ Congenital / Hereditary Disease
c) ☐ Influence of Drugs / Alcohol
d) ☐ Nervous / Mental / Emotional / Sleeping Disorder
e) ☐ Cosmetic Reason / Dental Care / Refractive Errors Correction
f) ☐ AIDS / STD / VD / HIV
g) ☐ Self-inflicted Injuries / Violation of Laws / Strike / Riots
h) ☐ None of the above

12. Was the patient pregnant at the time of hospitalisation? (For Females Only) ☐ No ☐ Yes, __________ months

13. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated above represent my medical opinion of his / her condition.

______________________	______________________	______________________
Name & Signature of Attending Doctor	Doctor / Hospital Stamp	Date

IP_06/2018/Ver2